CHILD'S ENROLLMENT RECORD

DIRECTOR'S USE ONLY

Date enrolled_____

Child's full legal name_____
First *Middle* *Last* *Nickname*

Date of Birth_____ **Sex**_____

Primary Hours of Care From_____To_____ **Days of Week in Care**_____

Child's Physical Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Family Information: **Child Lives with**_____

Parent's Name_____ Parent's Name_____

Address:_____Address_____

_____ _____

Home Phone:_____ Home Phone:_____

Employer:_____Employer:_____

Address:_____Address:_____

_____ _____

Work Phone_____Cell_____Work Phone_____Cell_____

Custody: Mother_____Father_____ Both_____ Other_____ Name_____

Emergency Contacts:
Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the children's center in case of illness, accident or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name_____

Home Phone_____Cell Phone_____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Name_____

Home Phone_____ Cell Phone _____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Please use additional sheet of paper to list name, address and phone number of any other people authorized to pick the child up.

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CHILD'S ENROLLMENT RECORD

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Medical Information:

Child's Physician/Health Resource _____

Telephone Number _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Hospital Preference _____

Name of Dentist _____ Telephone _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Meals typically served while in care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper

Emergency Care Plan instructions (if applicable) _____

_____

_____

_____

MISCELLANEOUS INFORMATION

List all known allergies _____

_____

List all identifying scars, birthmarks, skin discolorations _____

Special medical or dietary needs of child _____

_____

List any areas of concern _____

_____

My signature below verifies that:

I give permission to consult the child's physician/health resource listed above in case of emergency if parent/legal guardian cannot be reached.

I have received a copy of the "Know Your Child's Children's Center" brochure.

I was notified in writing of the disciplinary and expulsion policies used by the children's center.

I was provided the food and nutrition policies used by the children's center.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

_____

Signature of Custodial Parent or Legal Guardian **Date**

EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, and be the original notarized form.

A new notarized form is required when there is a change in legal guardianship.

Please Print Information

Child's Full Name:_____ Birthdate:_____

Allergies:_____

Medicines Routinely Taken:_____

Name of Custodial Parent(s)/Legal Guardian(s):_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Home Telephone _____ Cell Telephone_____ Work Telephone _____

Family Physician's Name/Health Care Resource:_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone (___)_____

Hospital Preference:_____
Name *City*

Medical Insurance Company:_____

Policy #:_____ Expiration Date:_____

Emergency Contact (if custodial parent/guardian cannot be reached**):**_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City,* *State,* *Zip Code*

Home Telephone _____ Cell Telephone _____ Work Telephone _____

Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child _____, in the event of an emergency at which time
(Child's Full Name)
I cannot be reached. I give consent to transport by ambulance if situation warrants it.

_____
Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ _____ 20_____
(Month) *(Day)* *(Year)*

by means of ☐ physical presence or ☐ online notarization by _____ who is personally known
(Name of Affiant)

to me or has produced _____as identification.
(Type of identification)

SEAL OF NOTARY

Signed:_____(*Signature of Notary)*

CHILD HEALTH AND DEVELOPMENT QUESTIONNAIRE

(*To be completed by parent or guardian*)

Date_____

Child's Full Name _____

Date of Birth _____ Race _____ Sex _____

Name of Parent or Guardian completing form _____

Please answer the questions on this form. We feel this information will help us be more effective in working with your child.

Childhood Disease Child has had		Date
Chicken Pox		_____
Measles	3 Day (Rubella)	_____
	10 Day (Rubella)	_____
Scarlet Fever		_____
Rheumatic Fever		_____
Mumps		_____
Strep Throat		_____

Is your child taking over-the-counter or prescribed medication regularly at home? ☐ Yes ☐ No

If yes, what?_____

Is your child taking vitamins regularly at home? Yes ☐ No ☐

If yes, what?_____

List any known allergies to food or environment_____

Describe the allergic reaction_____

Does your child complain of feeling ill often? ☐ Yes ☐ No

Have you ever suspected your child of having seizures? ☐ Yes ☐ No

Describe your child's appetite_____

Does your child dislike any foods? ☐ Yes ☐ No If so, what?_____

What does your child usually eat for breakfast before arriving at the center? _____

_____

How easily does your child fall asleep?_____

What is the usual bedtime? _____ Wake up time? _____

What is the usual naptime?_____ Wake up time?_____

Is the child completely toilet trained? ☐ Yes ☐ No

Does the child remain dry all night? ☐ Yes ☐ No

When did the child begin to walk alone? _____

Are other adults (not family) able to understand the child's speech? _____

Does your child have a regular playmate? ☐ Yes ☐ No Same Age ☐ Yes ☐ No

Older ☐ Yes ☐ No Younger ☐ Yes ☐ No

What is your child's favorite toy or activity at home?_____

Does your child have temper tantrums? ☐ Yes ☐ No

Does your child bite his nails? ☐ Yes ☐ No Twist his hair? ☐ Yes ☐ No

If you could describe your child in one word, what would it be?_____

Please list your child's strong points, such as happy, curious, loving, etc. _____

_____

Is there anything else, medical or otherwise, that we need to know about your child? _____

_____

Food Experience Permission Form

I give permission for my child _____ to participate in food related activities.

Please check one of the following:

_____My child DOES NOT have a food allergy or dietary restriction.

_____My child DOES have a food allergy or dietary restriction. He or she may participate, but may not eat or handle the following items (please list below)

_____
_____

_____My child DOES have a food allergy or dietary restriction. He or she may not participate in activities.

_____ _____

Parent Signature Date